Rates and Risk Reserves Briefing

March 30, 2006

Overview:

"Family Care Rates and Risk 101"

- Will provide an introduction to the full range of related topics
  - Depth on any single topic has been sacrificed
  - There is much more information to share
  - Some Wisconsin Partnership Program -- one example of a fully integrated model -- information will be shared where relevant
- Will identify other useful resources as needed

AGENDA

- Capitation rate overview
  - Roles & Responsibilities
- Rate methods and ranges
  - Family Care (FC) &
  - Wisconsin Partnership Program (WPP)
- Risk within managed care
- Solvency & program requirements
- Lessons learned

Definitions of rate-related terms available at:

http://dhfs.wisconsin.gov/LTCare/rfi/webcasts/033006.htm

- Actuarially sound
- Actuaries
- Benefit package
- Capitation
- Casemix
- CMO (= MCO)
- CMS
- Cost experience
- Encounter data
- IBNR
- PMPM
- Reinsurance
- Risk
- Risk adjustment
- Risk reserve
- Solvency protection
- WPP
- Working Capital

Capitation rate overview

- What is a capitation rate?
  - A payment made to a MCO each month for each enrolled member that month.
  - The MCO's payment is the same for every member and represents a projected *average* cost across all MCO members.
  - Covers all services and administration
  - No other payments may be made to MCO

Capitation rate overview (cont.)

- The rate may not be used as an upper limit on the cost of services each person receives
- Relationship to risk
  - Costs may exceed revenues in a given year

CMS's role in rate setting

- Establishes the general regulatory framework
- Has a policy 'checklist' to guide states, available at: http://dhfs.wisconsin.gov/LTCare/rfi/webcasts/033006.htm
- Approves rates submitted by the state
- Contributes to funding the rate

State's role in rate setting

- Must calculate an "actuarially sound rate"
  - A reasonable projection of the average per member per month (PMPM) cost to provide the Family Care benefit to the target population
- Works with CMS
  - Demonstrates compliance with rate checklist
- Works with MCO
  - Obtains data, shares information, presents analysis, and reviews contract language
- Contracts with an independent actuarial firm to calculate rates
  - PricewaterhouseCoopers is current firm

Managed care organization's role

- Understand the rate setting process and rate setting regulations.
- Understand the cost of doing business, especially within the context of how rates are set
- Develop a business plan
- Supply reliable and timely encounter data to state after providing services to members
- Manage the care
  - Plan and authorize services, person-by-person
  - Identify and implement appropriate efficiencies

Key issues and challenges for managed LTC programs

- Very high need members enrolled in organizations with low enrollment
  - Risk is spread over relatively small groups
- De-institutionalizations present challenges
  - how to adequately fund?
  - how to appropriately incentivize?
- Rate setting approaches are still developing
  - Methods for other managed care programs are much more established

Overview of rate setting process

- Contract is typically on a calendar year basis
- Rates are provided by November 1st
- Actuarial involvement begins in summer
  - Several months of heavy data analysis
- Collaboration between DHFS staff and MCOs is critical

Family Care rate overview

- Each MCO receives one (PMPM) rate
- Rate ranges over prior two years have been:
  - CY 2005: $1,829 – $2,321
  - CY 2006: $2,023 – $2,411
    - Variation based on acuity of each MCO's members

Family Care rate overview (cont.)

- Benefit package includes
  - Long-term care Medicaid card services:
    - Nursing home, ICF-MR, transportation, durable medical equipment, disposable medical supplies, therapies, home care, personal care
  - All waiver services
    - Residential care, case management, supportive home care, adult day care, adaptive equip., etc.

Rate development overview—general

- Uses encounter data from MCOs
  - Detailed, person-specific service and cost information
- Uses functional status from individual assessments
  - Long-term care functional screen information
- A statistical model correlates information from two data sources
  - Statistical / actuarial approach to calculate average cost

Methods overview—specific

- The statistical model identifies:
  - A minimum amount each MCO will get for every member
  - Certain functional characteristics strongly related to costs above the minimum, and
  - The level of additional cost associated with each functional characteristic - 'add-ons'.
- All Family Care members' LTCFS data is considered when identifying 'add-ons'
- A MCO's cap rate is calculated as:
  - The minimum amount for all members, plus
  - Add-on amounts for those members with characteristics related to an add-on.

Examples from Family Care (Cont.)

Base Amount	$750
LTCFS Characteristic	Additional 'Add-on'
Level of Care	
Developmental Disability 1A	$828
Developmental Disability 1B	$1,412
Developmental Disability 2	$858
SNF	$179
Count of IADLs	
3 Dependencies	$119
4 Dependencies	$246
5 Dependencies	$380
6 Dependencies	$1,007
Behaviors / Mental Health	
Self Injurious Behaviors	$275

Examples from Family Care (cont.)

- Calculating on individual's cap rate:
  - Individual A:
    - Each member gets the base amount - $750
    - Individual A has a DD1A level of care ($828 add-on), 3 IADLs ($119 add-on), but no self injurious behaviors.
    - A's cap rate is $750 + $828 + $119 = $1,697.

Examples from Family Care (cont.)

- Individual B:
  - Each member gets the base amount - $750
  - Individual B has no nursing home level of care, and no IADLs, but has self injurious behaviors ($275 add-on).
  - B's cap rate is $750 + $275 = $1,025.

Examples from Family Care (cont.)

LTCFS Characteristic	CMO 1		CMO 2
	100 members		150 members
Level of Care			
Developmental Disability 1A	2.0%		1.0%
Developmental Disability 1B	5.0%		2.0%
Developmental Disability 2	25.0%		20.0%
Skilled Nursing Facility (SNF)	25.0%		20.0%
Count of IADLs			
3 Dependencies	15.0%		10.0%
4 Dependencies	30.0%		25.0%
5 Dependencies	30.0%		25.0%
6 Dependencies	10.0%		5.0%
Behaviors / Mental Health			
Self Injurious Behaviors	10.0%		5.0%

Examples from Family Care (cont.)

- Calculating a MCO's cap rate:

  CMO 1
  - Each member gets the base amount - $750 x 100
  - 2 members have a DD1A level of care ($828 x 2), 5 individuals have a DD1B level of care ($1,412 x 5), etc. . .
  - The cap rate is ($750 x 100) + ($828 x 2) + ($1,412 x 5) + etc. =

    $143,026/ 100 =

    $1,430 PMPM.

Methods overview—specific (cont.)

- Higher rates to MCO with higher need members
- Rates trended forward to contract year
  - Accounts for inflationary increases
- Actuaries carry out and share this analysis
  - Details available on DHFS website

Wisconsin Partnership Program (WPP) rate overview

- Benefit package includes
  - All Medicaid card and all Medicaid waiver services
  - All Medicare services
- Each MCO receives several different (PMPM) rates
  - Depends upon the level of care of a given member
- Rate ranges over prior two years have been:
  - CY 2005: $2,816 – $4,442
  - CY 2006: $2,831 – $4,044
    - Some rate decreases due to shift of pharmacy to Medicare
    - Medicare reimbursement not included in the rates shown above. MCO Reimbursement for Medicare costs is through the federal Medicare program.

Methods overview

- LTC functional screen approach now used for the LTC rate
  - Similar to Family Care
- Acute care rate varies based on acuity of population
  - Diagnosis information is used to assess each MCO's average acuity level and rate

Introduction to risk

- What is risk?
  - An uncertain outcome = risk
  - Managed care risk = unpredicted service cost
    - Capitation revenue based on historical costs
    - Provider contracts establish rates for payment
    - Member service need may differ from historical average
- MCO gains experience to balance this

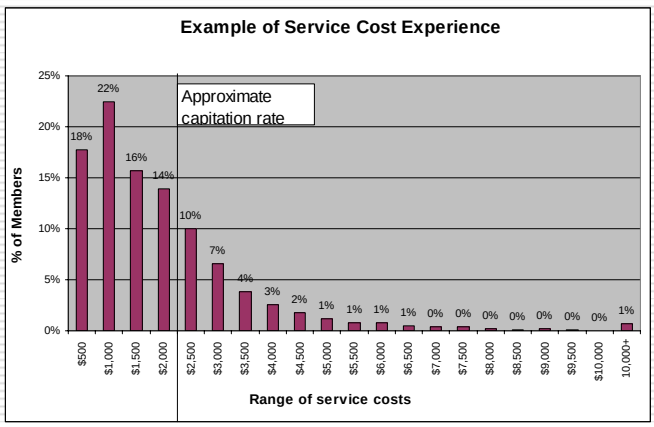
A picture of cost and risk

See next slide…

- Cost experience of a population similar to Family Care enrollees
- Capitation rate placed on the same graph

NOTE: This is just an example, but it is very close to reality

Costs and risk - the picture



Who manages risk

- State sets minimum funding requirements
  - Working capital, restricted reserves, solvency and termination requirements
- MCO (all partners) set minimum funding requirements & reserves
  - actuaries can help
- MCO through "Reinsurance"
  - Purchase of an insurance policy
    - Marketplace
    - State

Managing risk and business systems

- Good business systems = good risk management tools
- Member eligibility – systems to track enrollment
  - Capitation is on enrollment not served
- Resource allocation and care management teams
  - Information to understand service need, utilization and cost = utilization management
- Financial management systems
  - Accurate, timely information

Managing risk and information

- Information = key to risk management
  - What you don't know can hurt you
    - Systems to support eligibility –capitation is for eligibles
    - Service authorizations systems = utilization information
    - Claims payment systems = cost information
    - Good fiscal systems = timely decisions

Solvency protection in Family Care

- Three different contracting requirements
  - A layered approach to solvency
  - Developed by actuaries for Family Care
- Collectively = "capacity for financial solvency and stability"
  1. Working capital
  2. Risk reserve
  3. Solvency and termination requirements

Working capital

- Purpose
  - Provide liquid assets to manage ongoing operations
- Definition
  - Current assets minus current liabilities
- Requirements
  - Calculated by MCO and agreed by DHFS
  - Minimum requirement = 2% of budgeted annual capitation

Risk reserves

- Purpose
  - Reserves for continuity of care for enrolled members, accountability to taxpayers, and effective program administration
- Definition
  - Separate, identifiable restricted investment reserve account
- Requirement
  - Calculated on budgeted annual capitation revenue
  - Example - next slide…

Risk reserves (cont.)

Risk Reserve Calculation				
Range of Capitation Revenues				Cumulative Requirement
$ -	-	$ 5,000,000	8%	$ 400,000
$ 5,000,000	-	$ 10,000,000	5%	$ 250,000
$ 10,000,000	-	$ 20,000,000	3%	$ 300,000
$ 20,000,000	-	$ 50,000,000	2%	$ 600,000
>$ 50,000,000	-		1%	$ 450,000
Maximum reserve = $2,000,000				

Reserve example
annual capitation = $30,000,000

8%	5,000,000	$400,000
5%	5,000,000	$250,000
3%	10,000,000	$300,000
2%	20,000,000	$250,000
1%		
Total Reserve		$1,150,000

Solvency and termination requirements

- Purpose
  - Continuity of care / transition funds should the MCO become insolvent
- Definition
  - Assets must be immediately liquid
  - May be a county guarantee or an individual fund
- Requirements if annual capitation >$10,000,000
  - County Guarantee -$250,000
  - Agreed upon amount with DHFS for others

Meeting the requirements

- Where does the funding come from?
  - Sponsoring county (-ies)
  - Program earnings, or savings
  - Private health or long-term care partner
  - Other investors

Other resources

- These requirements are also outlined in...
  - DHFS administrative code: http://www.legis.state.wi.us/rsb/code/hfs/hfs010.pdf
  - The Family Care Contract: http://dhfs.wisconsin.gov/LTCare/StateFedReqs/CY06CMOContract.pdf

Solvency protection in WPP

- DHFS is not directly involved with this activity
- Wisconsin's Office of the Commissioner of Insurance has responsibility for fiscal oversight
- MCOs must meet all standard Wisconsin HMO financial requirements

Major lessons learned

- Must understand needs of potential members before they enroll
  - Must understand how those needs are likely to translate into costs of providing the care
- Investments in IT, internal systems, and financial / analytical staff are key
- Collaborate with other organizations that complement your strengths
  - Actuaries, third party administrators, etc.

Future briefings

- April 27 Care Management
- May 25 Quality Management
- Suggestions for future briefing topics welcome, please contact Elizabeth Childers at: ChildEA@dhfs.state.wi.us

Listserv information

- A listserv for planning grantees and other members of the public interested in managed long-term care expansion was deployed 2 weeks ago
- Sign up for the listserv at this website:

  http://dhfs.wisconsin.gov/ltcare/rfi/Listserv.htm

Future Questions

- If questions arise as you are viewing the recording of this presentation, please submit them to Elizabeth Childers at:

  ChildEA@dhfs.state.wi.us